WISCONSIN MEDICAID

PRIOR AUTHORIZATION / INTENSIVE IN-HOME TREATMENT ATTACHMENT (PA/ITA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Intensive In-Home Treatment Attachment (PA/ITA) Completion Instructions (HCF 11036A).

CHECK ONE: ❑ **Initial PA Request** ❑ **First Reauthorization** ❑ **Subsequent Reauthorization**

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Medicaid-Certified Clinic	5. Certified Clinic's Medicaid Provider Number
6. Name — Medicaid-Certified Performing Psychotherapist	7. Performing Psychotherapist's Medicaid Provider Number
8. Telephone Number — Psychotherapist	9. Discipline — Psychotherapist

SECTION III

10. Requested start date and end date for this authorization period. See instructions for maximum allowable authorization guidelines. If start date is prior to when request will be received at Wisconsin Medicaid, please indicate clinical rationale.

11. Number of hours of treatment to be provided to family over this PA grant period. Please note anticipated pattern of treatment by provider (e.g., two-hour session once a week by certified therapist, two-hour session once a week by family aide with certified therapist plus one-hour session twice a week by family aide independently).

SECTION III — Continued

12. Indicate for the period covered by this request:

- The number of hours the certified psychotherapist will provide treatment _____
- The number of hours the second team member will provider treatment _____
- The name and credentials of the second team member. Include degree and number of hours of supervised clinical work with severe emotional disturbance (SED) children (attach résumé, if available):

13. Indicate the travel time for the period covered by this request:

Certified psychotherapist		**Other therapist**	
Anticipated number of visits	_____	Anticipated number of visits	_____
Travel time per visit	x_____	Travel time per visit	x_____
=	_____	=	_____

SECTION IV

Note: The following additional information must be provided. If attaching copies of existing records to provide the information requested, limit attachments to two pages for the psychiatric evaluation and illness/treatment history. Highlighting relevant information is helpful. Do not attach M-team summaries, additional social service reports, court reports, or other similar documents unless directed to do so following initial review of the documentation.

14. Present a summary of the recipient's psychiatric assessment and differential diagnosis. Diagnoses on all five axes of *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised* are required. The summary must also present adequate information to support the diagnosis. A psychiatrist or a Ph.D. psychologist* must review and sign the summary and diagnoses.

*One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of health care providers in psychology.

Continued

SECTION IV — Continued

15. Present a summary of the recipient's illness / treatment / medication history and other significant background information. Define the potential for change. Note if the child is currently in out-of-home placement and, if so, the timeline for reintegration.

Continued

SECTION IV — Continued

16. Complete the checklist for determination that an individual meets the criteria for SED.

a. **The individual must meet all three of the following:**

- ❑ Be under the age of 21.
- ❑ Have an emotional disability that has persisted for at least six months.
- ❑ That same disability must be expected to persist for a year or longer.

b. **The individual has been diagnosed with a condition of SED** as defined by a mental or emotional disturbance listed in the most recent version of the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*.

❑ _____

c. **The individual has the following symptoms and functional impairments**

The individual must have 1 or 2.

1. Symptoms (must have one)
   - ❑ Psychotic symptoms.
   - ❑ Suicidality.
   - ❑ Violence.
2. Functional impairments (must have two)
   - ❑ Functioning in self care.
   - ❑ Functioning in the community.
   - ❑ Functioning in social relationships.
   - ❑ Functioning in the family.
   - ❑ Functioning at school/work.

d. **The individual is receiving services from two or more of the following service systems.**

- ❑ Mental Health.
- ❑ Social Services.
- ❑ Child Protective Services.
- ❑ Juvenile Justice.
- ❑ Special Education.

Eligibility criteria may be waived under certain circumstances

❑ This individual would otherwise meet the definition of SED, but has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided. Attach explanation.

❑ This individual would otherwise meet the definition of SED, but functional impairment has not persisted for six months, but in the judgment of the medical consultant, the nature of the acute episode is such an impairment in functioning that it is likely to be evident without the intensity of the treatment requested. Attach explanation.

17. Present an assessment of the family's strengths and weaknesses.

Continued

SECTION IV — Continued

18. Indicate the rationale for in-home treatment. Elaborate on this choice where prior outpatient treatment is absent or limited.

19. Indicate the expected date for termination of in-home treatment. Describe anticipated service needs following completion of in-home treatment and transition plans.

SECTION V

20. Please attach and label all the following:

a. The Prior Authorization/Request Form (PA/RF).
b. A physician's prescription for in-home treatment service.
c. Documentation that the recipient had a comprehensive HealthCheck screening within the past year. A copy of this documentation must be attached to all requests for reauthorizations (a copy of the original documentation may be used). **The initial request for these services must be received by Wisconsin Medicaid within one year of when the HealthCheck screening was dated.**
d. A multi-agency treatment plan.
e. An in-home psychotherapy treatment plan.
f. Results of either the Achenbach Child Behavior Checklist or the Child Adolescent Functional Assessment Scale (CAFAS).
g. A substance abuse assessment may be included. A substance abuse assessment **must** be included if substance abuse-related programming is part of the recipient's treatment program.

I attest to the accuracy of the information on this PA request. I understand that I am responsible for the supervision of the other team member(s) identified on this attachment. I, or someone with comparable qualifications, will be available to the other team member(s) at all times when they are in the home alone working with the child/family.

21. **SIGNATURE —** Certified Therapist	22. Date Signed
23. **SIGNATURE —** Supervising Therapist	24. Date Signed

Reset Form